

CMS Library
C2-07-13
7000 Security Blvd.
Baltimore, Maryland 21244

II

106TH CONGRESS
1ST SESSION

S. 479

To amend the title XXVII of the Public Health Service Act and other laws to assure the rights of enrollees under managed care plans.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 25, 1999

Mr. SCHUMER introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To amend the title XXVII of the Public Health Service Act and other laws to assure the rights of enrollees under managed care plans.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Equity in Womens
5 Health Act".

6 **SEC. 2. HEALTH INSURANCE BILL OF RIGHTS.**

7 Title XXVII of the Public Health Service Act (42
8 U.S.C. 300gg et seq.) is amended—

9 (1) by redesignating part C as part D; and

1 (2) by inserting after part B the following new
2 part:

3 “PART C—NONDISCRIMINATION AND HEALTH
4 PROSPECTUS

5 “SEC. 2770. NONDISCRIMINATION.

6 “(a) **ENROLLEES.**—A group health plan or health in-
7 surance issuer offering health insurance coverage (whether
8 or not a managed care plan or coverage) may not discrimi-
9 nate or engage (directly or through contractual arrange-
10 ments) in any activity, including the selection of service
11 area, that has the effect of discriminating against an indi-
12 vidual on the basis of race, culture, national origin, gen-
13 der, sexual orientation, language, socio-economic status,
14 age, disability, genetic makeup, health status, anticipated
15 need for health care services, or payer source.

“(b) PROVIDERS.—Such a plan or issuer may not discriminate in the selection of members of the health provider or provider network (and in establishing the terms and conditions for membership in the network) of the plan or coverage based on any of the factors described in subsection (a).

22 “(c) SERVICES.—Such a plan or issuer may not ex-
23 clude coverage (including procedures and drugs) if the ef-
24 fect is to discriminate in violation of subsection (a) or (b).

1 **“SEC. 2771. HEALTH PROSPECTUS; DISCLOSURE OF INFOR-**
2 **MATION.**

3 “(a) DISCLOSURE.—Each group health plan, and
4 each health insurance issuer providing health insurance
5 coverage, shall provide to each enrollee at the time of en-
6 rollment and on an annual basis, and shall make available
7 to each prospective enrollee upon request—

8 “(1) a prospectus that relates to the plan or
9 coverage offered and that meets the requirements of
10 subsection (b); and

11 “(2) additional information described in sub-
12 section (c).

13 “(b) PROSPECTUS.—

14 “(1) IN GENERAL.—Each prospectus under this
15 subsection for a plan or coverage—

16 “(A) shall contain the information de-
17 scribed in paragraphs (2) through (4) concern-
18 ing the plan or coverage,

19 “(B) shall contain such additional informa-
20 tion as the Secretary deems appropriate, and

21 “(C) shall be no longer than 3 pages in
22 length and in a format specified by the Sec-
23 retary for purposes of comparison by prospec-
24 tive enrollees.

25 “(2) QUALITATIVE INFORMATION.—The infor-
26 mation described in this paragraph is a summary of

1 the quality assessment data on the plan or coverage.

2 The data shall—

3 “(A) be the similar to the types of data as
4 are collected for managed care plans under title
5 XVIII of the Social Security Act, as determined
6 by the Secretary and taking into account dif-
7 ferences between the populations covered under
8 such title and the populations covered under
9 this title;

10 “(B) be collected by independent, auditing
11 agencies;

12 “(C) include—

13 “(i) a description of the types of
14 methodologies (including capitation, finan-
15 cial incentive or bonuses, fee-for-service,
16 salary, and withholds) used by the plan or
17 issuer to reimburse physicians, including
18 the proportions of physicians who have
19 each of these types of arrangements; and

20 “(ii) cost-sharing requirements for en-
21 rollees.

22 The information under subparagraph (C) shall in-
23 clude, upon request, information on the reimburse-
24 ment methodology used by the plan or issuer or
25 medical groups for individual physicians, but do not

1 require the disclosure of specific reimbursement
2 rates.

3 “(3) QUANTITATIVE INFORMATION.—The infor-
4 mation described in this paragraph is measures of
5 performance of the plan or issuer (in relation to cov-
6 erage offered) with respect to each of the following
7 and such other salient data as the Secretary may
8 specify:

9 “(A) The ratio of physicians to enrollees,
10 including the ratio of physicians who are obste-
11 trician/gynecologists to adult, female enrollees.

12 “(B) The ratio of specialists to enrollees.

13 “(C) The incentive structure used for pay-
14 ment of primary care physicians and specialists.

15 “(D) Patient outcomes for procedures, in-
16 cluding procedures specific to female enrollees.

17 “(E) The number of grievances filed under
18 the plan or coverage.

19 “(F) The number of requests for proce-
20 dures for which utilization review board review
21 or approval is required and the number (and
22 percentage) of such requests that are denied.

23 “(G) The number of appeals filed from de-
24 nial of such requests and the number (and per-
25 centage) of such appeals that are approved,

1 such numbers and percentages broken down by
2 gender of the enrollee involved.

3 “(H) Disenrollment data.

4 “(4) DESCRIPTION OF BENEFITS.—The infor-
5 mation described in this paragraph is a description
6 of the benefits provided under the plan or coverage,
7 as well as explicit exclusions, including a description
8 of the following:

9 “(A) Coverage policy with respect to cov-
10 erage for female-specific benefits, including
11 screening mammography, hormone replacement
12 therapy, bone density testing, osteoporosis
13 screening, maternity care, and reconstructive
14 surgery following a mastectomy.

15 “(B) The costs of copayments for treat-
16 ments, including any exceptions.

17 “(c) ADDITIONAL INFORMATION.—The additional in-
18 formation described in this subsection is information
19 about each of the following:

20 “(1) The plan’s or issuer’s structure and pro-
21 vider network, including the names and credentials
22 of physicians in the network.

23 “(2) Coverage provided and excluded, including
24 out-of-area coverage.

25 “(3) Procedures for utilization management.

1 “(4) Procedures for determining coverage for
2 investigational or experimental treatments, as well
3 as definitions for coverage terms.

4 “(5) Any restrictive formularies or prior ap-
5 proval requirements for obtaining prescription drugs,
6 including, upon request, information on whether or
7 not specific drugs are covered.

8 “(6) Use of voluntary or mandatory arbitration.

9 “(7) Procedures for receiving emergency care
10 and out-of-network services when those services are
11 not available in the network and information on the
12 coverage of emergency services, including—

13 “(A) the appropriate use of emergency
14 services, including use of the 911 telephone sys-
15 tem or its local equivalent in emergency situa-
16 tions and an explanation of what constitutes an
17 emergency situation;

18 “(B) the process and procedures for ob-
19 taining emergency services; and

20 “(C) the locations of (i) emergency depart-
21 ments, and (ii) other settings, in which physi-
22 cians and hospitals provide emergency services
23 and post-stabilization care.

24 “(8) How to contact agencies that regulate the
25 plan or issuer.

1 “(9) How to contact consumer assistance agen-
2 cies, such as ombudsmen programs.

3 “(10) How to obtain covered services.

4 “(11) How to receive preventive health services
5 and health education.

6 “(12) How to select providers and obtain refer-
7 rals.

8 “(13) How to appeal health plan decisions and
9 file grievances.

10 “(d) STATE AUTHORITY TO REQUIRE ADDITIONAL
11 INFORMATION.—

12 “(1) IN GENERAL.—Subject to paragraph (2),
13 this section shall not be construed as preventing a
14 State from requiring health insurance issuers, in re-
15 lation to their offering of health insurance coverage,
16 to disclose separately information (including com-
17 parative ratings of health insurance coverage) in ad-
18 dition to the information required to be disclosed
19 under this section.

20 “(2) CONTINUED PREEMPTION WITH RESPECT
21 TO GROUP HEALTH PLANS.—Nothing in this part
22 shall be construed to affect or modify the provisions
23 of section 514 with respect to group health plans.”.

1 **SEC. 3. AMENDMENTS TO THE PUBLIC HEALTH SERVICE**
2 **ACT.**

3 (a) APPLICATION TO GROUP HEALTH INSURANCE
4 COVERAGE.—Subpart 2 of part A of title XXVII of the
5 Public Health Service Act, as amended by the Omnibus
6 Consolidated and Emergency Supplemental Appropria-
7 tions Act, 1999 (Public Law 105–277), is amended by
8 adding at the end the following new section:

9 **“SEC. 2707. MANAGED CARE REQUIREMENTS.**

10 “Each health insurance issuer shall comply with the
11 applicable requirements under part C with respect to
12 group health insurance coverage it offers.”.

13 (b) APPLICATION TO INDIVIDUAL HEALTH INSUR-
14 ANCE COVERAGE.—Subpart 3 of part B of title XXVII
15 of the Public Health Service Act, as amended by the Om-
16 nibus Consolidated and Emergency Supplemental Appro-
17 priations Act, 1999 (Public Law 105–277), is amended
18 by adding at the end the following new section:

19 **“SEC. 2753. MANAGED CARE REQUIREMENTS.**

20 “Each health insurance issuer shall comply with the
21 applicable requirements under part C with respect to indi-
22 vidual health insurance coverage it offers, in the same
23 manner as such requirements apply to group health insur-
24 ance coverage.”.

25 (c) MODIFICATION OF PREEMPTION STANDARDS.—

1 (1) GROUP HEALTH INSURANCE COVERAGE.—

2 Section 2723 of such Act (42 U.S.C. 300gg-23) is
3 amended—

4 (A) in subsection (a)(1), by striking “sub-
5 section (b)” and inserting “subsections (b) and
6 (c)”;

7 (B) by redesignating subsections (c) and
8 (d) as subsections (d) and (e), respectively; and

9 (C) by inserting after subsection (b) the
10 following new subsection:

11 “(c) SPECIAL RULES IN CASE OF MANAGED CARE
12 REQUIREMENTS.—Subject to subsection (a)(2), the provi-
13 sions of section 2707 and part C, and part D insofar as
14 it applies to section 2707 or part C, shall not prevent a
15 State from establishing requirements relating to the sub-
16 ject matter of such provisions so long as such require-
17 ments are at least as stringent on health insurance issuers
18 as the requirements imposed under such provisions.”.

19 (2) INDIVIDUAL HEALTH INSURANCE COV-
20 ERAGE.—Section 2762 of the Public Health Service
21 Act (42 U.S.C. 300gg-62) is amended—

22 (A) in subsection (a), by striking “sub-
23 section (b), nothing in this part” and inserting
24 “subsections (b) and (c)”, and

1 (B) by adding at the end the following new
2 subsection:

3 “(c) SPECIAL RULES IN CASE OF MANAGED CARE
4 REQUIREMENTS.—Subject to subsection (b), the provi-
5 sions of section 2753 and part C, and part D insofar as
6 it applies to section 2753 or part C, shall not prevent a
7 State from establishing requirements relating to the sub-
8 ject matter of such provisions so long as such require-
9 ments are at least as stringent on health insurance issuers
10 as the requirements imposed under such section.”.

11 (d) ADDITIONAL CONFORMING AMENDMENTS.—

12 (1) Section 2723(a)(1) of the Public Health
13 Service Act (42 U.S.C. 300gg-23(a)(1)) is amended
14 by striking “part C” and inserting “parts C and D”.

15 (2) Section 2762(b)(1) of the Public Health
16 Service Act (42 U.S.C. 300gg-62(b)(1)) is amended
17 by striking “part C” and inserting “part D”.

18 (e) ASSURING COORDINATION.—Section 104(1) of
19 the Health Insurance Portability and Accountability Act
20 of 1996 (Public Law 104-191) is amended by striking
21 “under this subtitle (and the amendments made by this
22 subtitle and section 401)” and inserting “title XXVII of
23 the Public Health Service Act, under part 7 of subtitle
24 B of title I of the Employee Retirement Income Security

1 Act of 1974, and chapter 100 of the Internal Revenue
2 Code of 1986”.

3 **SEC. 4. MANAGED CARE REQUIREMENTS UNDER THE EM-**
4 **PLOYEE RETIREMENT INCOME SECURITY**
5 **ACT OF 1974.**

6 (a) IN GENERAL.—Subpart B of part 7 of subtitle
7 B of title I of the Employee Retirement Income Security
8 Act of 1974, as amended by the Omnibus Consolidated
9 and Emergency Supplemental Appropriations Act, 1999
10 (Public Law 105–277), is amended by adding at the end
11 the following:

12 **“SEC. 714. MANAGED CARE REQUIREMENTS.**

13 “(a) IN GENERAL.—Subject to subsection (b), a
14 group health plan (and a health insurance issuer offering
15 group health insurance coverage in connection with such
16 a plan) shall comply with the applicable requirements of
17 part C of title XXVII of the Public Health Service Act.

18 “(b) REFERENCES IN APPLICATION.—In applying
19 subsection (a) under this part, any reference in such part
20 C—

21 “(1) to a health insurance issuer and health in-
22 surance coverage offered by such an issuer is
23 deemed to include a reference to a group health plan
24 and coverage under such plan, respectively;

1 “(2) to the Secretary is deemed a reference to
2 the Secretary of Labor;

3 “(3) to an applicable State authority is deemed
4 a reference to the Secretary of Labor; and

5 “(4) to an enrollee with respect to health insur-
6 ance coverage is deemed to include a reference to a
7 participant or beneficiary with respect to a group
8 health plan.”.

9 (b) MODIFICATION OF PREEMPTION STANDARDS.—

10 Section 731 of the Employee Retirement Income Security
11 Act of 1974 (42 U.S.C. 1191) is amended—

12 (1) in subsection (a)(1), by striking “subsection
13 (b)” and inserting “subsections (b) and (c)”;

14 (2) by redesignating subsections (c) and (d) as
15 subsections (d) and (e), respectively; and

16 (3) by inserting after subsection (b) the follow-
17 ing new subsection:

18 “(c) SPECIAL RULES IN CASE OF MANAGED CARE
19 REQUIREMENTS.—Subject to subsection (a)(2), the provi-
20 sions of section 714 and part C of title XXVII of the Pub-
21 lic Health Service Act, and subpart C insofar as it applies
22 to section 714 or such part, shall not be construed to pre-
23 empt any State law, or the enactment or implementation
24 of such a State law, that provides protections for individ-

1 uals that are equivalent to or stricter than the protections
2 provided under such provisions.”.

3 (c) CONFORMING AMENDMENTS.—

4 (1) Section 732(a) of the Employee Retirement
5 Income Security Act of 1974 (29 U.S.C. 1185(a)) is
6 amended by striking “section 711” and inserting
7 “sections 711 and 713”.

8 (2) The table of contents in section 1 of the
9 Employee Retirement Income Security Act of 1974
10 is amended by inserting after the item relating to
11 section 713 the following new item:

“Sec. 714. Managed care requirements.”.

12 **SEC. 5. MANAGED CARE REQUIREMENTS UNDER THE IN-**
13 **TERNAL REVENUE CODE OF 1986.**

14 (a) IN GENERAL.—Subchapter B of part B of part
15 7 of subtitle B of title I of the Internal Revenue Code
16 of 1986 is amended by adding at the end the following
17 new section:

18 **“SEC. 9813. MANAGED CARE REQUIREMENTS.**

19 “(a) IN GENERAL.—Subject to subsection (b), a
20 group health plan shall comply with the applicable require-
21 ments of part C of title XXVII of the Public Health Serv-
22 ice Act.

23 “(b) REFERENCES IN APPLICATION.—In applying
24 subsection (a) under this subchapter, any reference in
25 such part C—

1 “(1) to the Secretary is deemed a reference to
2 the Secretary of the Treasury; and

3 “(2) to an applicable State authority is deemed
4 a reference to the Secretary.”.

5 (b) CLERICAL AMENDMENT.—The table of sections
6 in subchapter B of chapter 100 of such Code is amended
7 by inserting after the item relating to section 9812 the
8 following new item:

“Sec. 9813. Managed care requirements.”.

9 **SEC. 6. MANAGED CARE REQUIREMENTS UNDER MEDI-**
10 **CARE, MEDICAID, AND THE FEDERAL EM-**
11 **PLOYEES HEALTH BENEFITS PROGRAM**
12 **(FEHBP).**

13 (a) MEDICARE.—Section 1852 of the Social Security
14 Act (42 U.S.C. 1395w–22) is amended by adding at the
15 end the following new subsection:

16 “(1) MANAGED CARE REQUIREMENTS.—Each
17 Medicare+Choice organization that offers a
18 Medicare+Choice plan described in section 1851(a)(1)(A)
19 shall comply with the applicable requirements of part C
20 of title XXVII of the Public Health Service Act in the
21 same manner as such requirements apply with respect to
22 health insurance coverage offered by a health insurance
23 issuer, except to the extent such requirements are less pro-
24 tective of enrollees than the requirements established
25 under this part.”.

1 (b) MEDICAID.—Section 1932(b)(8) of the Social Se-
2 curity Act (42 U.S.C. 1396u-2(b)(8))—

3 (1) by striking “AND MENTAL HEALTH” and in-
4 serting “, MENTAL HEALTH, AND MANAGED CARE”,

5 (2) by inserting “and of part C” after “of part
6 A”, and

7 (3) by inserting before the period at the end the
8 following: “, except to the extent such requirements
9 are less protective of enrollees than the requirements
10 established under this title”.

11 (c) FEDERAL EMPLOYEES’ HEALTH BENEFITS PRO-
12 GRAM (FEHBP).—Chapter 89 of title 5, United States
13 Code, is amended—

14 (1) by inserting after the item relating to sec-
15 tion 8905a the following new section:

16 **“§ 8905b. Application of managed care requirements**

17 “Each health benefit plan offered under this chapter
18 shall comply with the applicable requirements of part C
19 of title XXVII of the Public Health Service Act in the
20 same manner as such requirements apply with respect to
21 health insurance coverage offered by a health insurance
22 issuer, except to the extent such requirements are less pro-
23 tective of enrollees than the requirements established
24 under this chapter.”; and

1 (2) in the table of sections, by inserting the fol-
 2 lowing item after the item relating to section 8905a:

“8905b. Application of managed care requirements.”.

3 **SEC. 7. EFFECTIVE DATES.**

4 (a) GENERAL EFFECTIVE DATE FOR GROUP
 5 HEALTH PLANS.—

6 (1) IN GENERAL.—Subject to paragraph (2),
 7 the amendments made by section 2, subsections (a),
 8 (c)(1), and (d) of section 3, and sections 5 and 6
 9 shall apply with respect to group health insurance
 10 coverage for group health plan years beginning on or
 11 after July 1, 2000 (in this section referred to as the
 12 “general effective date”) and also shall apply to por-
 13 tions of plan years occurring on and after January
 14 1, 2001.

15 (2) TREATMENT OF GROUP HEALTH PLANS
 16 MAINTAINED PURSUANT TO CERTAIN COLLECTIVE
 17 BARGAINING AGREEMENTS.—In the case of a group
 18 health plan, or group health insurance coverage pro-
 19 vided pursuant to a group health plan, maintained
 20 pursuant to 1 or more collective bargaining agree-
 21 ments between employee representatives and 1 or
 22 more employers ratified before the date of enactment
 23 of this Act, the amendments described in paragraph
 24 (1) shall not apply to plan years beginning before
 25 the later of—

1 (A) the date on which the last collective
2 bargaining agreements relating to the plan ter-
3 minates (determined without regard to any ex-
4 tension thereof agreed to after the date of en-
5 actment of this Act), or

6 (B) the general effective date.

7 For purposes of subparagraph (A), any plan amend-
8 ment made pursuant to a collective bargaining
9 agreement relating to the plan which amends the
10 plan solely to conform to any requirement added by
11 such amendments shall not be treated as a termi-
12 nation of such collective bargaining agreement.

13 (b) GENERAL EFFECTIVE DATE FOR HEALTH IN-
14 SURANCE COVERAGE.—The amendments made by section
15 2 and subsections (b), (c)(2), and (d) of section 3 shall
16 apply with respect to individual health insurance coverage
17 offered, sold, issued, renewed, in effect, or operated in the
18 individual market on or after the general effective date.

19 (c) EFFECTIVE DATE FOR COORDINATION.—The
20 amendment made by section 3(e) shall take effect on the
21 date of the enactment of this Act.

22 (d) FEDERAL PROGRAMS.—The amendments made
23 by section 6 shall take effect on January 1, 2001.

○

CMS Library
C2-07-13
7500 Security Blvd.
Baltimore, Maryland 21244

CMS LIBRARY



3 8095 00010412 1